

Insights from Carilion Clinic: Healthcare Reform, Accountable Care, Medical Homes

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Key FY '09 Carilion Clinic Stats



- Employees 12,305
- Licensed beds 1,215
- Admissions 49,642
- Avg. daily census 624
- Avg. daily ED visits 508.4
- Total ED visits 185,595

Healthcare in the U.S.

- Large, complicated, ever-evolving, high variability
- 1960 – 2007: Outgrown all other economic activity
 - Health spending grew from 5.2% to 16% of the economy
 - Out of pocket expenses shrunk to 11% while public “share” grew to 16%
- Endless stream of billable events
 - High margin ambulatory services
 - Procedure oriented services
 - No money for coordination
- Malpractice vs standard of care

Said Again: Healthcare Spending

- Dollars are skewed toward separate payments to separate providers for discrete services, particularly specialty and technology intensive services
- Volume is rewarded
- No incentives for coordination, efficiency
- Disincentive for improving quality (in the hospital)

Wide Variation Across States

- **Massachusetts Model**
- **Maryland – hospital budget regulation**
- **North Carolina – relatively generous payments to PCP**
- **New York – nonprofit insurances and hospital**
- **Tennessee – free-wheeling competition**
- **Ohio – mostly solo and private practice physicians**

Worries Abound

- Can't change a 50-year-old system overnight
- Grave concern about “unknown” and “unknowable”
- Broad cuts to hospitals
- Decrease DSH payments
- Public Plan
- End of life
- Illegal aliens
- Pace
- How to pay for it

Putting U.S. Healthcare on Right Track

- Strengthen and broaden coverage
- Lower trajectory of healthcare spending
- Improve outcomes (e.g. quality)
- Assure value: Quality vs cost
- Align incentives and coordinate care
- Don't break the bank

What's In the Proposed Reform Packages?

- 1600 page bill - House
- Devil's in the details
- You can't add more services and reduce costs without change
- Change is hard and takes time to stick

Key Components - Medicare

- Market Basket – Both houses recommend year over year reductions in market basket update to inpatient and outpatient services; House includes skilled nursing homes
- Medicare Commission – Senate: Establishes an independent commission to submit proposals for reducing Medicare costs
- DSH – Both houses recommend reductions; House ties to reductions in uninsured
- Geographic Variation – House: directs IOM to address inappropriate variation in Medicare expenditures

Key Components - Medicaid

- DSH – Both houses recommend reductions; House ties to reductions in uninsured
- Expands Medicaid eligibility to 150% of Federal poverty level
- Recent news – some help with pending Medicaid cliff

Key Components – Medical Education

- **GME: Both houses recommend redistribution of unused resident slots. House prioritizes resident training in ambulatory or rural settings, primary care and areas with low physicians to general population ratio**

Key Components-Quality

- Pay for Performance

- CURRENT

- “Voluntary” but face penalty if fail to submit
 - Physicians can earn bonuses

- PROPOSED

- “Claw Back” beginning 2013
 - If meet, exceed, improve quality, hospitals could get back slightly higher than withhold
 - Home Health agencies, hospices, SNF’s – later
 - Implement similar requirements for physicians

Key Components-Quality

- **Readmission Adjusted Payments – Both houses recommend decreased payments or penalty for “avoidable” readmissions**
- **Hospital acquired conditions – Senate version increases policy penalties for Medicare; House version extends policy to Medicaid**

Demonstration Projects & Pilot Programs

- **Bundled payments to align incentives for care coordination**
- **ACO – Accountable for overall care of Medicare beneficiaries. Option for Medicaid**
- **Drug Discount: 340 B - extends participation to children's hospitals, Medicare – dependent rural hospitals, sole community hospitals, etc.**

How's Virginia Doing?

- **Considered low cost, high quality state**
- **Dartmouth Atlas: Recognizes Virginia as in lowest 10% of states in Medicare spending per beneficiary**
- **American Health Insurance Plans: Virginia in lowest quartile in insurance premium costs**
- **Commonwealth Fund: Second highest quartile in quality of care**

Virginia hospitals and health systems

107 acute care, psychiatric, rehabilitation and specialty hospitals

14,000 beds



108,000 employees

In 2008:

\$900 million in community benefit

- **\$399** million in charity care
- **\$188** million in Medicaid shortfall
- **\$313** million in other community services

\$419 million in bad debt

\$570 million in Medicare shortfall

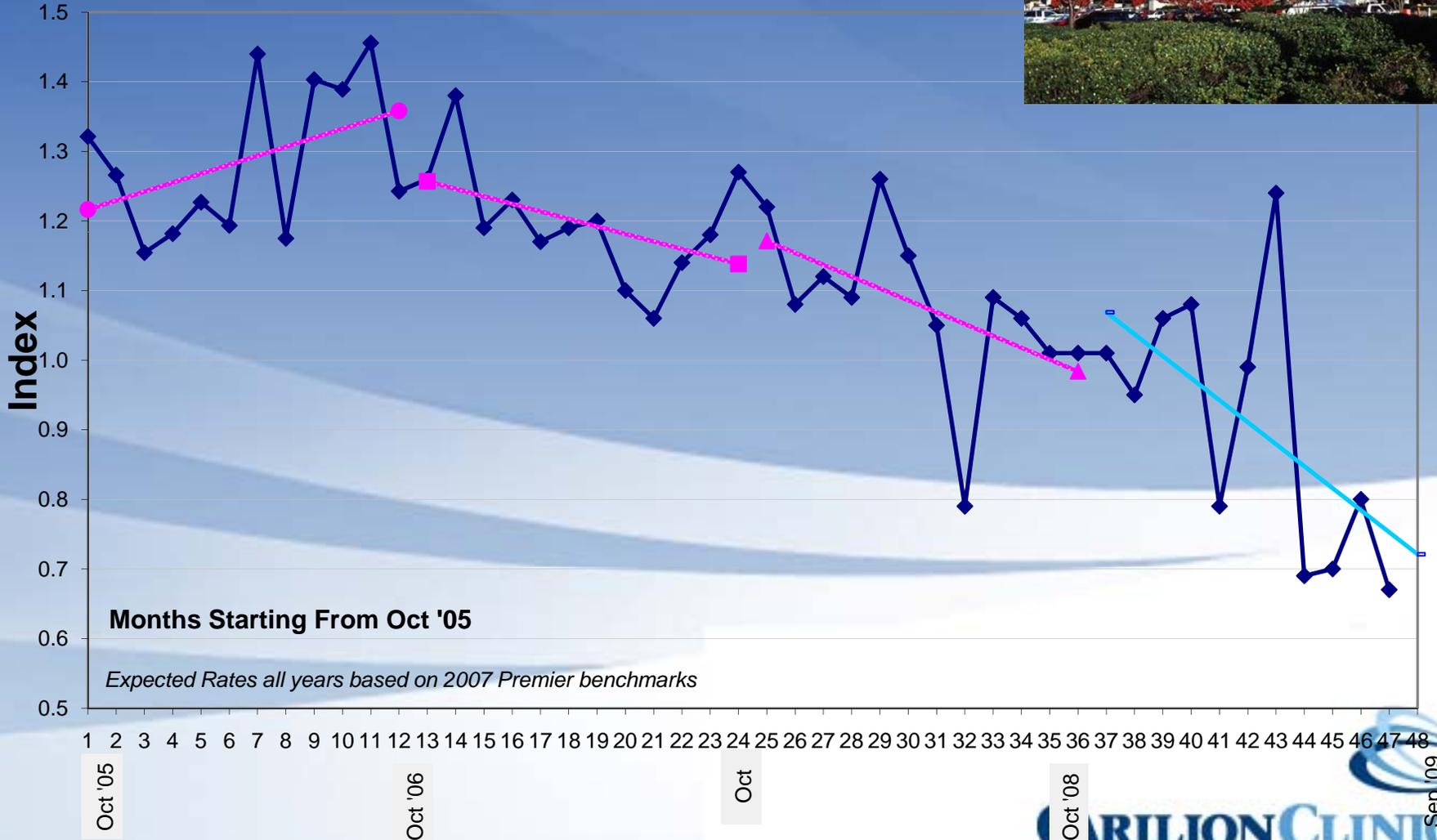
Virginia Magnet-Recognized Organizations	City	Recognized Year
Bon Secours Memorial Regional Medical Center	Mechanicsville	2009
Bon Secours St. Mary's Hospital	Richmond	2008
Carilion Medical Center	Roanoke	2003
Inova Fair Oaks Hospital	Fairfax	2009
Inova Fairfax Hospital	Falls Church	1997
Inova Loudoun Hospital	Leesburg	2006
Lynchburg General Hospital	Lynchburg	2005
Martha Jefferson Hospital	Charlottesville	2006
Mary Washington Hospital	Fredericksburg	2009
Montgomery Regional Hospital	Blacksburg	2009
Reston Hospital Center	Reston	2007
Sentara Norfolk General Hospital	Norfolk	2008
UVA Health System	Charlottesville	2006
VCU Health System	Richmond	2006
Virginia Baptist Hospital	Lynchburg	2005
Winchester Medical Center	Winchester	2008



Photos from recent Magnet phone call ceremony at Mary Washington Hospital

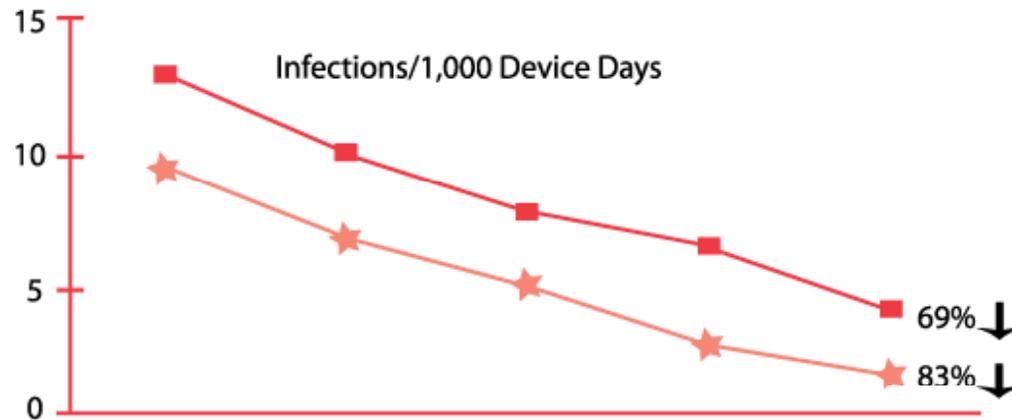
Carilion Medical Center, Roanoke

Observed/Expected Mortality Index FYE'06 - FYE'09



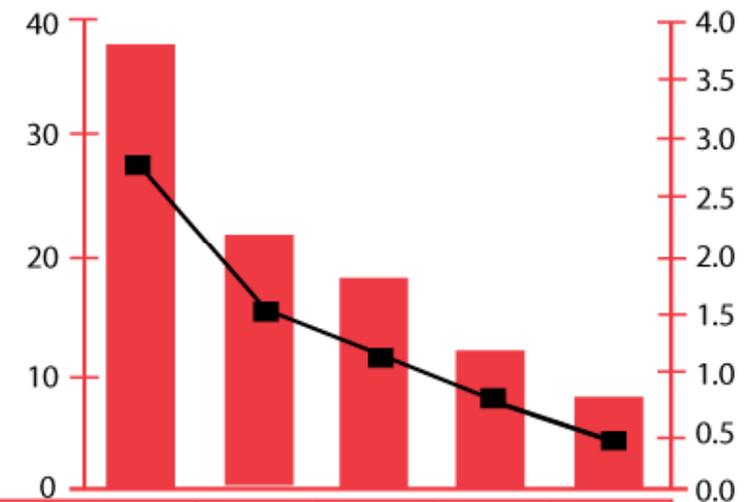
VCU Medical Center, Richmond

Figure 1. HAI Rates at VCU Medical Center
Adult ICUs, 2003-2007



	2003	2004	2005	2006	2007
■ CLABSI	12.8	9.9	7.7	6.4	4.0
★ VAP	9.4	6.7	4.9	2.7	1.6

Figure 2. Device Related MRSA Infections in
Adult ICUs, 2003-2007



	2003	2004	2005	2006	2007
■ Number	38	22	18	12	8
■ Rate/1,000 Patient Days	2.86	1.55	1.16	0.76	.049





McDonnell eyes health-care changes at state level

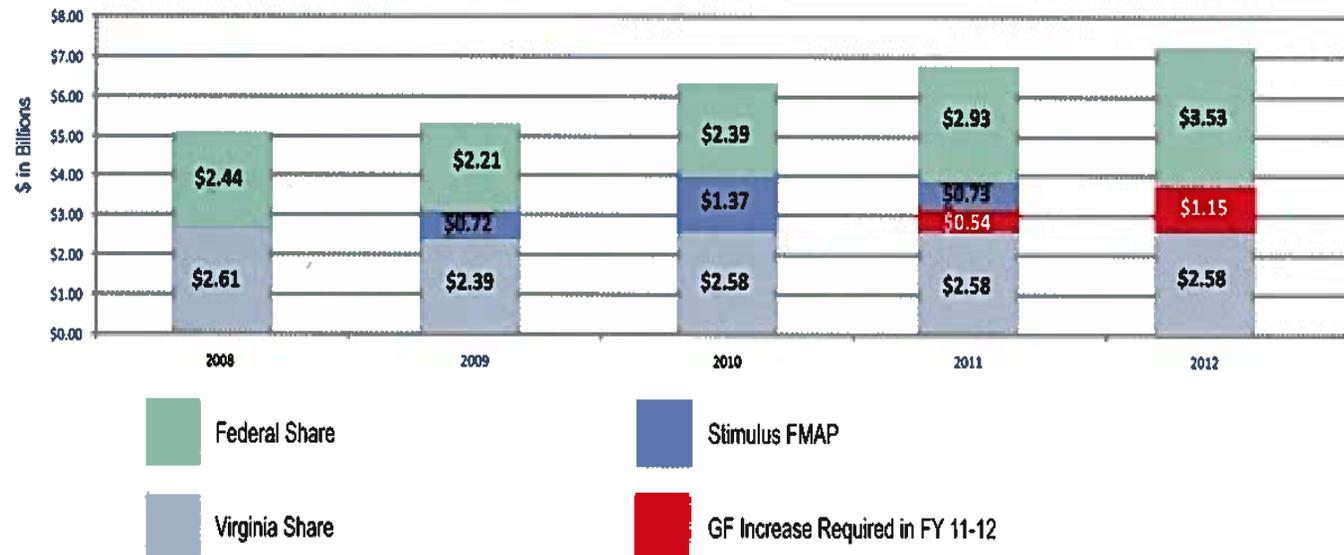
**Richmond
Times-Dispatch**

11/16/09 - Gov.-elect Bob McDonnell worries that a national health-care overhaul that includes a public option would lead to diminished access to quality care and reduced choice for Virginians...



Virginia's Medicaid Cliff

Impact of Federal Stimulus



**\$1.7
Billion**

Additional state funds needed for FY11-12 to accommodate projected growth and replace temporary federal FMAP funds.

The American Recovery and Reinvestment Act of 2009 provided \$86.6 billion to shore up state Medicaid programs. Virginia will receive \$1.63 billion in temporary, enhanced Medicaid payments between state fiscal years (SFY) 2009 and 2011. The funds fill budget holes created by reduced state tax revenues dedicated to Medicaid.

As the Medicaid program is funded jointly by the state and federal governments, failure to meet the additional state funding needs could result in a cut to Medicaid of \$3.4 billion.

Bending the Curve: Long Term Solutions

1. Building foundational tools such as IT systems
2. Comparative Effectiveness Research
3. Address scope of practice for healthcare workers
4. Address fee-for-service Medicare and Medicaid payment systems
5. Align providers
6. Support better individual choices
7. Support patient performance, palliative/end of life

What Do We Do?

- **Be realistic; cutting other public programs will no longer cover short fall in health care costs and tax increases would need to be so large as to not be feasible**
- **Take time; plan for the long term**
- **Experiment; facilitate pilot projects**



CARILION CLINIC
finding better ways

This We Believe

- **30% waste; yet patients don't get what they need**
- **50% - no empirical evidence**
 - **no comparative effectiveness**
- **Healthcare is highly fragmented**
- **Variation is the enemy of quality**
- **Culture trumps strategy**
- **Integrated care works- multi-specialty, planned and coordinated**

Waste, Effectiveness & Variations

- Waste is characterized by misuse, overuse and underuse of health care resources
- Wide variance in the care delivered in US hospitals as measured by clinical outcomes, quality measures, costs, and resource utilization rates
- Factors that lead to waste & variation
 - Availability
 - Lack of evidence-based medicine in practice
 - Economic factors
 - Organizational culture
 - Limited accountability

Our Crystal Ball

- **More (and more) care occurs outside the hospital**
- **Technological advances hard(er) to discern and pay for**
- **Physicians and hospitals more aligned**
- **Provider and Payment reform necessary**
- **No reform can be successful without physician engagement and leadership**
- **Revenues will decline**

Physician Practice at a Crossroads...

- New physicians are seeking “employment” more than traditional practice settings
- Physicians are not business-people
- Continued importance of family considerations, work-life balance, more women physicians
- Call coverage is major issue
- Indebtedness continues to be a factor in specialty practice decisions
- Many physicians don't need/use hospitals

Contributors to Cost Growth

- Aging population- 2%
- Price growth- 22%
- New technologies- over 50%
- Defensive medicine- real, complex, lessor contributor
- Overuse and inappropriate care
 - 1/3 of surgeries of limited value
 - Up to 2/3 of carotid endarterectomies

Quality of Healthcare in U.S.

- 439 Indicators of quality for 30 acute and chronic conditions as well as preventative care
- 12 Metropolitan areas across United States
- Patients received 54% of recommended care:
 - range by condition:
10.5% - 78.7%

Summary

- We spend too much
- Spending is growing at an unsustainable rate
- We get too many things we don't need
- We often don't get what we do need
- We overspend and under perform other industrialized countries

Our Responsibility

- **Reclaim 30%,
if not,
 - **Deterioration**
 - **Continued rationing****
- **Produce consistently good, transparent results**



Only Physician-Led Health Care Systems Can Do This

- **Physician orders spend the money and drive care**
- **Clinical teams have the knowledge/experience to ferret out value**

Our View of a Clinic

- Large interdisciplinary group practice dedicated to integrated and coordinated care producing excellent efficient patient care supported by education and informed by research
- Physicians are key leaders
- Organized around the physician group
- Hospitals work together with physicians in support of patients' needs

Medical Home

- Comprehensive primary care
- Imperative for wellness
- Management of chronic disease
- Elimination of unnecessary potentially harmful care
- Avoid preventable diseases
- Stay healthy longer
- Avoid hospitalization, ED visits, costly diagnostic work-ups

Medical Home

- Nurse case manager in office
- Disease registries
- Detailed clinical outcome reporting
- Team-based care using guidelines and good coordination & communication
- Internet access for questions, medications, appointments, record access (MyChart)

Care Coordination:

- Intensive management of high risk patients (recurrent admissions/ED visits)
- Outreach to pts with defined diagnoses that need more attention (DM, HTN, Asthma, CHF)
- Enriched visits with education sessions
- Ensure appropriate screening is performed

Medical Home

- Fee-for-service payment not consist
- Payments need to promote community and population focus, quality, service, and cost management
- Grow primary care “panels”
- Encourage coordination of care with specialists- who, what, when, why

What is an Accountable Care Organization (ACO)?

- A provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population

Three components of ACO infrastructure



- Local Accountability for Cost, Quality, and Capacity



- Shared Savings



- Performance Measurement

ACOs will look very different, but a few characteristics are essential

1

Can provide or manage
continuum of care as a
real or virtually
integrated delivery
system

2

Are of a
sufficient size
to support
comprehensive
performance
measurement

3

Capable of
internally
distributing
shared savings
payments

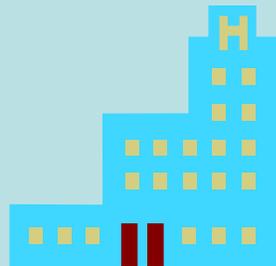
What providers comprise an ACO? It varies.

Accountable Care Organization

Primary Care



Hospital



Specialists



Other Possible Components:

Home Health

Mental Health

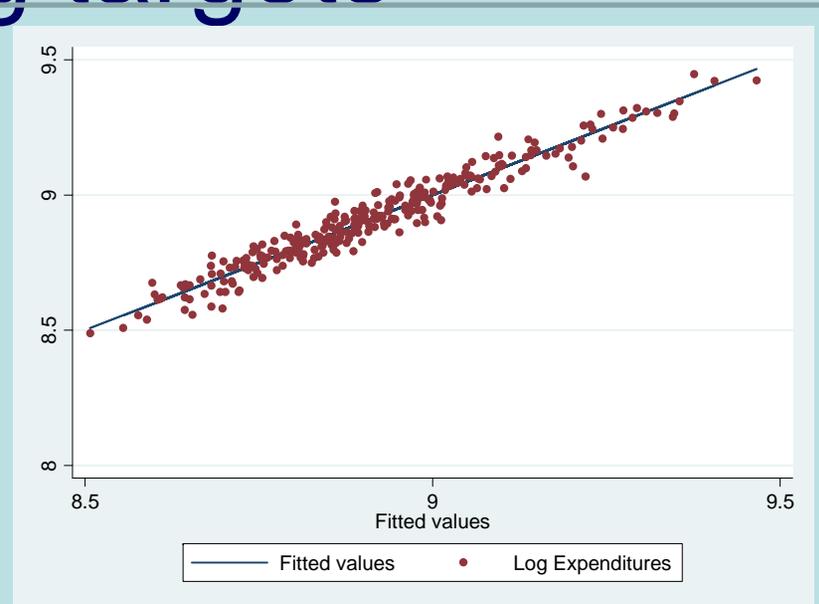
Rehab Facilities

Local accountability is the goal

- **Current proposals** (bundled payments, chronic disease management, pay-for-performance) while important, do not promote accountability for per capita cost, quality and capacity.
- **In the ACO model**, providers are accountable for cost and quality
 - Shared savings payments are based on total patient expenditures and quality targets

Calculating savings based on spending targets

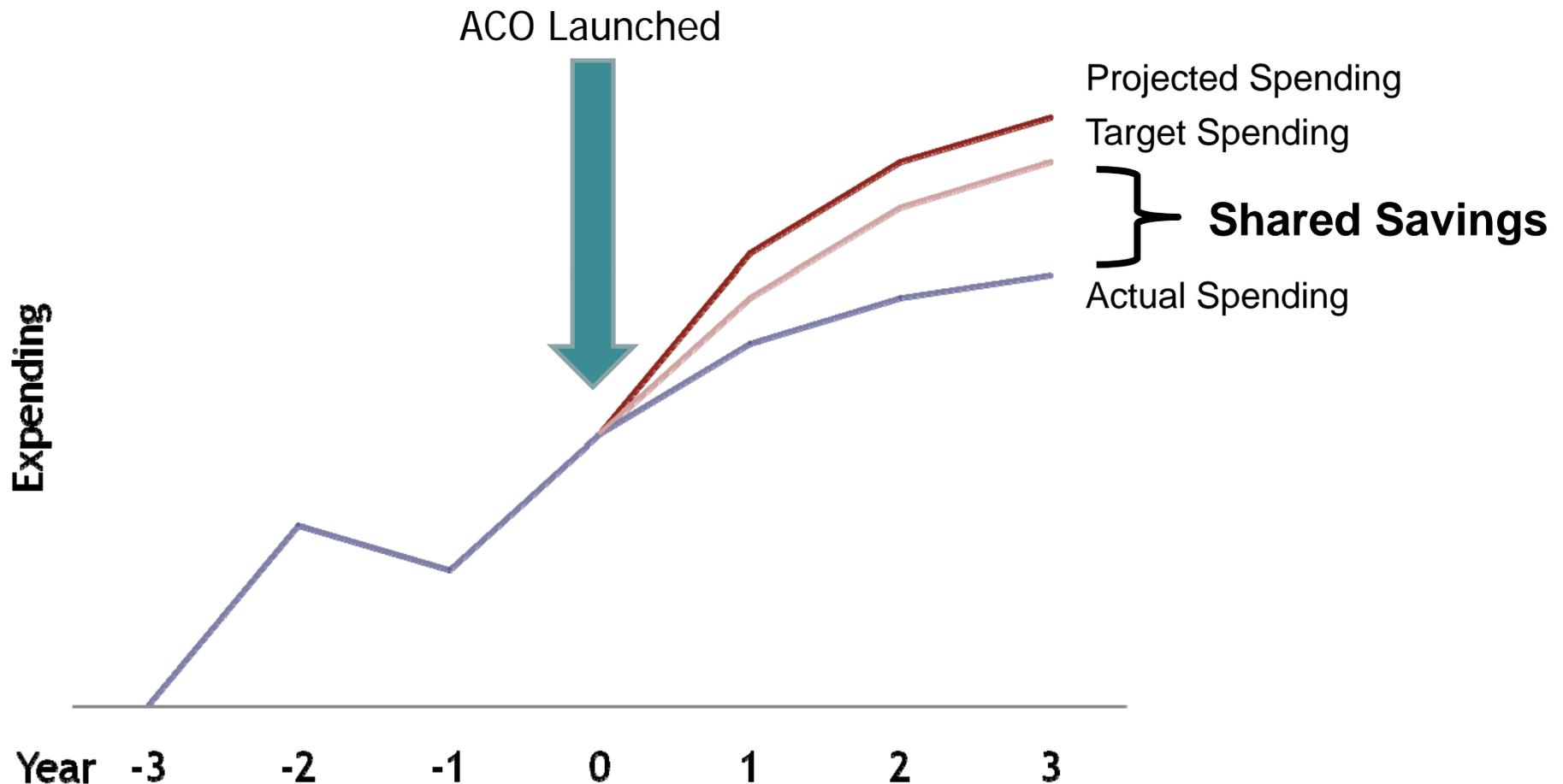
- Patients are assigned to physicians in the ACO
- 3-year historical average of total expenditures for ACO is calculated
- Expenditures for ACO are predicted
- Expenditure target is negotiated between the ACO and its payers.



Predicted and actual log age-sex-race Medicare expenditures, 2003-05, for EHMSs with at least 5000 people.

$N = 287$, $R^2 = .94$, Error = .04 Percent

Calculating savings based on spending targets



Multiple initiatives within the ACO model:

\$800M (Target Expenditures)

- \$525M (Traditional Fee for Service Payments)
 - \$115M (Bundled Payments for Specific Conditions)
 - \$150M (PMPM Payments for Medical Home)
-

\$10M (Available Shared Savings)



(80/20 agreed upon split)



\$8M to the Providers

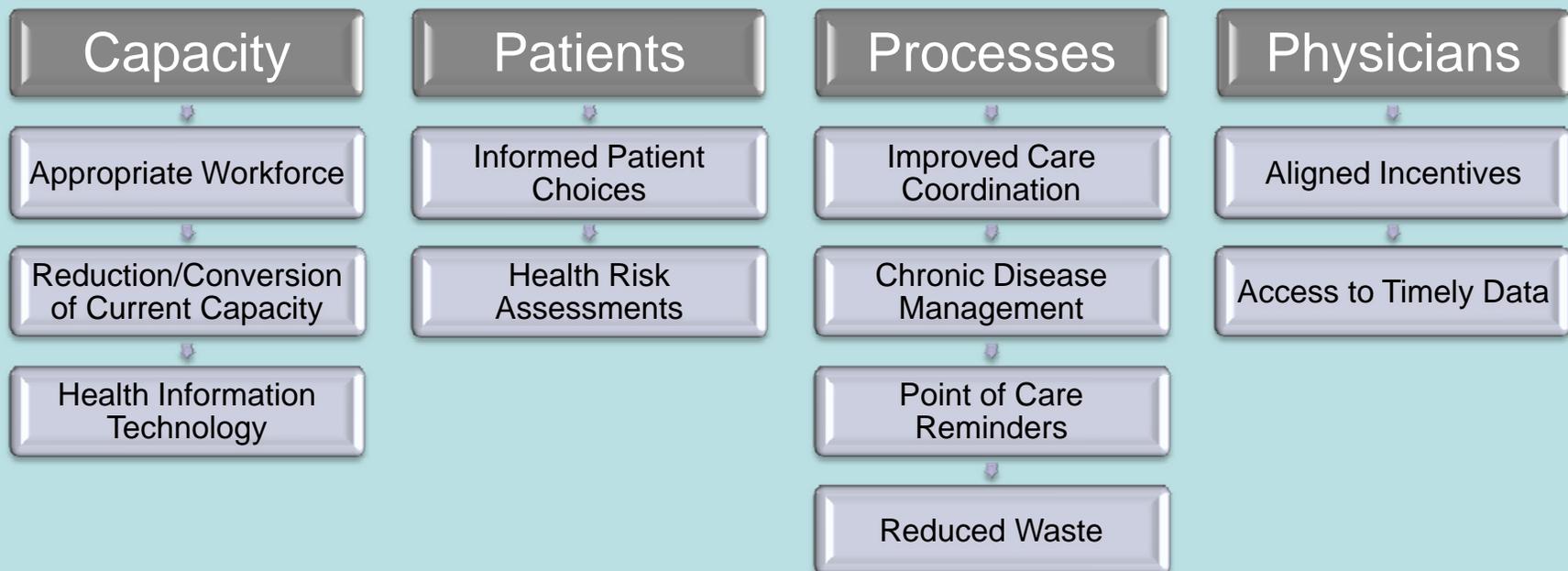
\$2M to the Payers

Why would providers participate?

- Improved professional working environment
- Realization that at some point volume and intensity will not be able to be increased further
- Understanding that the care currently being delivered is not always in the best interest of the patient
- Knowledge of other reform efforts underway and understanding that at least one will be implemented by Congress quickly.

How do ACOs reduce expenditures?

- Through systematic efforts to improve quality and reduce costs across the organization:



Medicaid Challenges

- High risk children
 - Medical homes effective
 - ACO networks based in Children's Hospitals promising
 - Issues: risk profiling, mobility, social services
- High risk dual-eligible adults
 - Challenging population
 - Many psychosocial service needs
 - Medical homes likely helpful
 - ACOs too complex to assess risk profiles and cost trends

Evidence it is Working

- Reduced costs/in-patient over \$200
- Reductions in mortality rate
- Reductions in hospital-acquired infections
- Access and service standards
- Navigated or Coordinated scheduling
- Team focused care
- New programs- neurointerventional, electrophysiology, interventional pulmonary, adolescent gynecology
- A 26 year old wife and mother